Lake County, Ohio

2012 Spousal Surcharge
Employee Statement

Employee Name _____ **Department** _____

In an effort to control costs a spousal surcharge has been instituted for employees covered under the healthcare plan whose spouses are eligible for healthcare insurance through their employer, but opt to take Lake County's healthcare program. The criteria is as follows:

1. Spousal surcharge applies only to employees that cover their spouse on the County Healthcare Program.

2. Eligible employee's spouse maintains full time employment and is eligible for an employer sponsored health plan through their full time employment, but chooses to enroll under the County's Healthcare Program.

The spousal surcharge will be $75.00 per month as long as the spouse remains eligible for other coverage.

Please check **only one** of the coverage options below:

☐ *Does Not Apply*
I am enrolled for single or employee + child(ren). (or)
My spouse is self-employed, (or)
My spouse is employed part-time, (or)
My spouse is not employed, (or)
My spouse is a County employee
I am waiving medical coverage.

☐ *Spousal Waiver**
I attest to the fact that my spouse is employed full-time and does not have access to employer-sponsored medical coverage and/or is not eligible for such coverage. Should these circumstances change, and my spouse does become eligible for employer-sponsored coverage under another employer, I must notify the County within 30 days of such occurrence. My spouse will be required to seek medical coverage under his/her current employer's plan at that time he/she becomes eligible or continue to stay on the County's healthcare plan with a spousal surcharge of $75.00 per month.

I agree to notify the County regarding my spouse's eligibility for another employer-sponsored medical plan, and I attest to the truth regarding my spouse's current eligibility.
***(MUST COMPLETE SPOUSE'S EMPLOYER STATEMENT OF COVERAGE)**

☐ *Spousal Surcharge*
I acknowledge that my spouse is eligible for coverage with her/his current employer but will cover my spouse as a dependent under my medical insurance policy. I understand that I will be charged a spousal surcharge of $75 per month.

☐ *Spousal Other Coverage*
I acknowledge that my spouse is eligible for coverage with her/his current employer. I will not cover my spouse as a dependent under my medical insurance policy and will not be subject to the surcharge.

I agree to notify the County immediately if my above circumstances changes (i.e.: marriage, divorce, spouse becomes eligible for coverage elsewhere, etc.). I understand if I fail to notify the County of my change in eligibility status, I may be subject to any consequence set forth by in accordance with the County Health Insurance Guidelines.

_____ _____
Employee Signature Date

**** Contact Benefits Office for Employer Statement of Coverage***

2012 Lake County
Spouse's Employer Statement of Coverage

Lake County Employee Information (Please Print Clearly):

Lake County Employee Name: _____

Lake County Employee Social Security Number: _____

Spouse Name ("Spouse"): _____

Spouse Company Name ("Company"): _____

To Be Filled Out by Spouse's Employer Representative:

I , _____ ("Representative") do hereby acknowledge that the above
Print Company Representative Name

spouse is currently an employee of _____ ("Company").
Print Company Name

Our Company currently (select ONLY one situation):

_____ **A.** does not offer any employer sponsored healthcare plan at this time.

_____ **B.** offers an employer sponsored healthcare plan but the above named Employee does not qualify to participate in plan.

_____ **C.** offers an employer sponsored healthcare plan and the above named Spouse currently **does not** participate in that plan. I understand that the above named Spouse will be eligible to elect coverage during open enrollment. Plan information is as follows:

[1]Healthcare Insurance Carrier's Name: _____
[1]Date of Open Enrollment: _____

I do herby attest that the above information is complete and accurate to the best of my knowledge:

	Spouse's Company Representative	Lake County Employee	Employee's Spouse
Signature:	_____	_____	_____
Date:	_____	_____	_____